

■ Claims Submission Checklist

Check Every Claim Before You Send It — Get Paid Faster, Fewer Denials

Why Use This Checklist? A claim that is sent with missing or wrong information gets denied. Fixing a denied claim takes time and money. Use this checklist to check every claim before it goes out. Clean claims = faster payments = healthier cash flow for your practice.

SECTION 1 — Patient Information

What To Check		Notes / Reminder
■	Patient's Full Legal Name Correct The name on the claim matches exactly what is on the patient's insurance card — including middle initial if needed.	<i>Even one typo = denial</i>
■	Date of Birth Is Accurate The patient's birth date is entered correctly. This is used to confirm the patient's identity with the insurance.	<i>Verify against ID</i>
■	Patient Address Is Current The patient's home address is up to date. Some insurances send paperwork to this address.	<i>Confirm at each visit</i>
■	Patient's Relationship to Insured Is the patient the insurance holder, a spouse, a child, or another dependent? This must be selected correctly.	<i>Check insurance card</i>
■	Social Security or Member ID Is Correct The patient's insurance member ID number matches exactly what is printed on their insurance card.	<i>No spaces or dashes unless required</i>

SECTION 2 — Insurance Information

What To Check		Notes / Reminder
■	Insurance Name and Address Are Correct The insurance company name and their claims mailing/electronic address is correct for this claim type.	<i>Use payer ID for electronic</i>
■	Policy / Group Number Is Accurate The policy number and group number from the insurance card are entered exactly as they appear.	<i>No guessing — confirm card</i>
■	Primary vs. Secondary Insurance Confirmed If a patient has two insurance plans, it is confirmed which one is primary and which is secondary.	<i>Use COB rules if unsure</i>
■	Insurance Eligibility Verified Before Visit Insurance was checked (verified) before the patient came in to confirm their coverage is active.	<i>Use eligibility portal</i>
■	Prior Authorization Obtained (if required) If the service required pre-approval from the insurance, the authorization number is attached to the claim.	<i>Include auth number on claim</i>

SECTION 3 — Provider & Facility Information

What To Check		Notes / Reminder
■	Rendering Provider's Name & NPI Correct The NPI (National Provider Identifier) of the doctor or provider who actually performed the service is on the claim.	<i>10-digit number, no dashes</i>
■	Billing Provider NPI & Tax ID Correct The practice or billing entity's NPI and Tax ID (EIN) are entered in the billing provider section.	<i>Confirm with front desk</i>
■	Referring Provider Info Included (if needed) If a patient was referred by another doctor, that doctor's name and NPI are on the claim where required.	<i>Required for some plans</i>
■	Service Facility Address Is Correct The address where the service was performed is entered correctly — this matters for place of service codes.	<i>Use actual location address</i>
■	Place of Service Code Matches Location The two-digit place of service code (e.g., 11 = office, 21 = hospital) matches where care was given.	<i>Use CMS POS code list</i>

SECTION 4 — Diagnosis & Procedure Codes

What To Check		Notes / Reminder
■	ICD-10 Diagnosis Codes Are Correct The diagnosis codes (ICD-10) match exactly what the provider documented in the patient's chart/notes.	<i>Use most specific code</i>
■	Primary Diagnosis Is Listed First The main reason for the visit is the first diagnosis code. Supporting conditions come after.	<i>Order matters for payment</i>
■	CPT/HCPCS Procedure Codes Are Correct The procedure codes match exactly the services and treatments that were performed and documented.	<i>Match to op report/notes</i>
■	Modifiers Are Attached When Needed Any two-digit modifiers that describe special circumstances (bilateral, multiple procedures, etc.) are added.	<i>Only use if documented</i>
■	Units Are Entered Correctly The number of units (how many times a service was done or how much was used) is correct.	<i>Errors cause overpayment or denial</i>
■	Charges Are Correct The billed amount (charge) for each procedure matches your practice's current fee schedule.	<i>Update fee schedule annually</i>

SECTION 5 — Service Details & Final Review

What To Check	Notes / Reminder
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■	Date of Service Is Accurate The date the patient was seen or the service was performed is entered correctly — not today's date.	<i>Critical for timely filing</i>
■	Claim Form Type Is Correct Using CMS-1500 for professional/office claims and UB-04 for hospital/facility claims.	<i>Wrong form = rejection</i>
■	Signature on File Confirmed The patient's signature authorizing the release of information and assignment of benefits is on file.	<i>Keep signed forms 7 years</i>
■	Coordination of Benefits Info Included If billing a secondary insurance, the primary insurance payment and EOB information are attached.	<i>Required for secondary billing</i>
■	Final Claim Review Completed A second set of eyes (or a scrubbing tool) has reviewed the claim for any errors before submission.	<i>Use claim scrubber software</i>
■	Claim Submitted and Confirmation Saved The claim has been submitted and you have saved the confirmation/tracking number for follow-up.	<i>Log in billing system</i>

■ **Pro Tip:** Most insurance companies have their own specific rules. Always check each payer's guidelines for special requirements. When in doubt, call the payer's provider services line before submitting.

Use this checklist for every claim • Clean Claims Get Paid Faster • Medical Billing Best Practices